TEXAS DEPARTMENT OF INSURANCE
Division of Workers' Compensation - Medical Fee Dispute Resolution (MS-48)
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MEDICAL FEE DISPUTE RESOLUTION FINDINGS AND DECISION

GENERAL INFORMATION

Requestor Name
BHF HEALTHCARE, LLC

Respondent Name
GREAT WEST CASUALTY CO

MFDR Tracking Number
M4-16-2796-01

Carrier's Austin Representative
Box Number 01

MFDR Date Received
May 10, 2016

REQUESTOR'S POSITION SUMMARY

Requestor's Position Summary: "First, physical therapy required authorization and was requested and approved for treatment base [sic] on medical necessity. The authorization approved the visits as medically necessary and did not stipulate a time limit for treatment, but indicates services were authorized and medically necessary... Please review the attached documentation and request that the carrier to re-evaluate their process and honor what was initially authorized by the carrier and reimburse for the additional time that was performed to the workers comp claimant."

Amount in Dispute: $2,997.66

RESPONDENT'S POSITION SUMMARY

Respondent's Position Summary: "The EOBs note a lack of medical necessity among other reasons. The Texas Labor Code requires reimbursement for all medical expenses to be fair and reasonable and be designed to ensure the quality of medical care and to achieve effective medical cost control."

Response Submitted by: Flahive, Ogden & Latson

SUMMARY OF FINDINGS

Date(s) of Service	Disputed Service(s)	Amount In Dispute	Amount Due
August 3, 2015 through November 6, 2015	97110, 97035 and 97032	$2,997.66	$1,641.36

FINDINGS AND DECISION

This medical fee dispute is decided pursuant to Texas Labor Code §413.031 and applicable rules of the Texas Department of Insurance, Division of Workers' Compensation.

Background

1. 28 Texas Administrative Code §133.307 sets out the procedures for resolving medical fee disputes.
2. 28 Texas Administrative Code §134.600 sets out the guidelines for preauthorization, concurrent review, and voluntary certification of healthcare.
3. 28 Texas Administrative Code §134.203 sets out the sets out the fee guidelines for the reimbursement of workers' compensation professional medical services provided on or after March 1, 2008.

4. The insurance carrier reduced payment for the disputed services with the following claim adjustment codes:
   - 119 – Benefit maximum for this time period or occurrence has been reached
   - W3 – Additional payment made on appeal/reconsideration
   - 168 – Billed charge is greater than maximum unit value or daily maximum allowance for physical therapy/physical medicine services
   - 193 – Original payment decision is being maintained. This claim was processed properly the first time
   - 275 – The charge was disallowed; as the submitted report does not substantiate the service being billed
   - B12 – Services not documented in patients' medical records
   - 285 – Please refer to the note above for detailed explanation of the reduction
   - Note – Documentation submitted does not show medical necessity for additional units. No additional allowance is recommended
   - P12 – Workers' Compensation jurisdictional fee schedule adjustment
   - 1014 – The attached billing has been re-evaluated at the request of the provider. Based on this re-evaluation, we find our original review to be correct. Therefore, no additional allowance appears to be warranted
   - 6577 – Reconsideration of previous reconsideration

Issues

1. Did the requestor submit documentation to support that disputed CPT Code 97035-GP was billed on September 21, 2015 through September 28, 2015?
2. Did the requestor submit documentation to support that disputed CPT Code 97032 rendered on October 2, 2015 through November 6, 2015 and CPT Code 97110 rendered on August 3, 2015 through September 28, 2015 were preauthorized?
3. Did the requestor bill in accordance with 28 Texas Administrative Code §134.203(b)?
4. Is the requestor entitled to reimbursement for the disputed services?

Findings

1. The requestor seeks reimbursement for CPT Codes 97110, 97035 and 97032. Review of the CMS-1500s supports that the requestor billed the insurance carrier for CPT Code 97032 and not CPT Code 97035.

   Per 28 Texas Administrative Code 134.307 "(c) Requests. Requests for MFDR shall be filed in the form and manner prescribed by the division. Requestors shall file two legible copies of the request with the division. (2) Health Care Provider or Pharmacy Processing Agent Request. The requestor shall provide the following information and records with the request for MFDR in the form and manner prescribed by the division. The provider shall file the request with the MFDR Section by any mail service or personal delivery. The request shall include... (J) a paper copy of all medical bill(s) related to the dispute, as originally submitted to the insurance carrier in accordance with this chapter and a paper copy of all medical bill(s) submitted to the insurance carrier for an appeal in accordance with §133.250 of this chapter (relating to General Medical Provisions); (K) a paper copy of each explanation of benefits (EOB) related to the dispute as originally submitted to the health care provider in accordance with this chapter or, if no EOB was received, convincing documentation providing evidence of insurance carrier receipt of the request for an EOB..."

   The Requestor seeks reimbursement for CPT Code 97035 for dates of service September 21, 2015 through September 28, 2015 as identified on the Table of Disputed Services. Review of the submitted documentation finds that the requestor billed the insurance carrier for CPT Code 97032, which is not identified as the disputed CPT code on the Table of Disputed Services. Due to the insufficient documentation to support that the requestor billed the insurance carrier for CPT Code 97035, the Division cannot consider the review of this code. As a result, the disputed CPT Code 97035 is not eligible for review.

2. The requestor seeks reimbursement for CPT code 97032-GP rendered on October 2, 2015 through November 6, 2015 and CPT Code 97110 rendered on August 3, 2015 through September 28, 2015. The insurance carrier denied/reduced the disputed services with denial/reduction code(s) indicated above.

   Review of the EOBs submitted with the DWC060 request documents that the insurance carrier denied/reduced the disputed services with denial/reduction code(s) "285 – Please refer to the note above for detailed explanation of the reduction - Note – Documentation submitted does not show medical necessity for additional units. No additional allowance is recommended."

   28 Texas Administrative Code §134.600 states in pertinent part "(p) Non-emergency health care requiring preauthorization includes... (5) physical and occupational therapy services, which includes those services listed in the Healthcare Common Procedure Coding System (HCPCS) at the following levels: (A) Level I code range for Physical Medicine and Rehabilitation ..."

The Division finds that CPT Codes 97110 and 97032 are subject to preauthorization. The requestor submitted several copies of preauthorization determination letters and concurrent review approvals for review.

Review of the submitted preauthorization determination letters and concurrent review approvals finds the following:

Preauthorization Determination Issued by IMO	Response Date	Requested Services	Preauthorized Timeframes	Determination	Disputed Services
	7/29/15	95851, 97010, 97035, 97110, 97530, 95832, 97535 and 95831	July 29, 2015 through August 31, 2015	9 Sessions of PT 3 x per week for 3 weeks	8/3/15 – 97110 8/7/15 – 97110 8/10/15 – 97110 8/12/15 – 97110 8/17/15 – 97110 8/24/15 – 97110
	8/31/15	95851, 97010, 97035, 97110, 97530, 95832, 97535 and 95831	August 31, 2015 through October 6, 2015	Additional 12 sessions of PT 3 x per week/4 weeks	9/4/15 – 97110 9/8/15 – 97110 9/11/15 – 97110 9/21/15 – 97110 9/23/15 – 97110 9/25/15 – 97110 9/28/15 – 97110
	10/22/15	95851, 97010, 97035, 97110, 97530, 95832, 97535 and 95831	October 22, 2015 through November 30, 2015	Additional 12 sessions of PT 3 x per week /4 weeks	The requestor seeks reimbursement for CPT code 97032, which is not identified as a preauthorized service on the preauthorization letters provided by the requestor.
	11/25/15	95851, 97010, 97035, 97110, 97530, 95832, 97535 and 95831	Date extended through December 11, 2015	Concurrent review approval	

28 Texas Administrative Code §134.600 states in pertinent part, "(c) The insurance carrier is liable for all reasonable and necessary medical costs relating to the health care: (1) listed in subsection (p) or (q) of this section only when the following situations occur... (B) preauthorization of any health care listed in subsection (p) of this section that was approved prior to providing the health care... (C) concurrent utilization review of any health care listed in subsection (q) of this section that was approved prior to providing the health care..."

The Division finds that the requestor submitted insufficient documentation to support that CPT Code 97032 rendered October 2, 2015 through November 6, 2015 was obtained as required pursuant to 28 Texas Administrative Code 134.600(p)(5)(A). As a result, reimbursement for CPT Code 97032 rendered on October 2, 2015 through November 6, 2015 cannot be recommended.

The Division finds that the requestor submitted sufficient documentation to support that CPT Code 97110 rendered on August 3, 2015 through September 28, 2015 was preauthorized and rendered within the preauthorized timeframes. As a result, the services are reviewed pursuant to 28 Texas Administrative Code §134.203 (b).

3. 28 Texas Administrative Code §134.203 states in pertinent part, "(b) For coding, billing, reporting, and reimbursement of professional medical services, Texas workers' compensation system participants shall apply the following: (1) Medicare payment policies, including its coding; billing; correct coding initiatives (CCI) edits; modifiers; bonus payments for health professional shortage areas (HPSAs) and physician scarcity areas (PSAs); and other payment policies in effect on the date a service is provided with any additions or exceptions in the rules..."

   The Division reviewed the CMS1500s submitted for disputed dates of service rendered on August 3, 2015 through September 28, 2015. The Division completed NCCI edits to identify potential edit conflicts that may affect reimbursement. The following was identified:

Date(s) of Service: August 24, 2015

Billed CPT Codes: 97110-GP, 97530-GP, 97002-GP, G8981-CI-GP and G8982-CI-GP

NCCI Edit Conflicts: No NCCI edit conflicts were identified for disputed CPT Code 97110-GP. As a result, reimbursement is determined pursuant to 28 Texas Administrative Code §134.203(c).

Date(s) of Service: August 3, 2015 and August 12, 2015

Billed CPT Codes: 97112-GP and 97110-GP

NCCI Edit Conflicts: No NCCI edit conflicts were identified for disputed CPT Code 97110-GP. As a result, reimbursement is determined pursuant to 28 Texas Administrative Code §134.203(c).

Date(s) of Service: August 7, 2015, August 10, 2015, August 17, 2015, September 4, 2015, September 8, 2015, September 11, 2015, September 14, 2015

Billed CPT Codes: 97530-GP and 97110-GP

NCCI Edit Conflicts: No NCCI edit conflicts were identified for disputed CPT Code 97110-GP. As a result, reimbursement is determined pursuant to 28 Texas Administrative Code §134.203(c).

Date(s) of Service: September 21, 2015, September 23, 2015, September 25, 2015 and September 28, 2015

Billed CPT Codes: 97530-GP, 97110-GP and 97032-GP

NCCI Edit Conflicts: No NCCI edit conflicts were identified for disputed CPT Code 97110-GP. As a result, reimbursement is determined pursuant to 28 Texas Administrative Code §134.203(c).

The Division finds that the requestor is entitled to reimbursement for CPT Code 97110-GP rendered on August 3, 2015 through September 28, 2016. Reimbursement is determined pursuant to 28 Texas Administrative Code 134.203(c).

4. 28 Texas Administrative Code §134.203 states in pertinent part, "(c) To determine the MAR for professional services, system participants shall apply the Medicare payment policies with minimal modifications. (1) For service categories of Evaluation & Management, General Medicine, Physical Medicine and Rehabilitation, Radiology, Pathology, Anesthesia, and Surgery when performed in an office setting, the established conversion factor to be applied is $52.83. For Surgery when performed in a facility setting, the established conversion factor to be applied is $66.32. (2) The conversion factors listed in paragraph (1) of this subsection shall be the conversion factors for calendar year 2008. Subsequent year's conversion factors shall be determined by applying the annual percentage adjustment of the Medicare Economic Index (MEI) to the previous year's conversion factors, and shall be effective January 1st of the new calendar year..."

   28 Texas Administrative Code §134.203 states in pertinent part, "(h) When there is no negotiated or contracted amount that complies with Labor Code §413.011, reimbursement shall be the least of the: (1) MAR amount; (2) health care provider's usual and customary charge, unless directed by Division rule to bill a specific amount; or (3) fair and reasonable amount consistent with the standards of §134.1 of this title."

   To determine reimbursement, the Division applies Medicare's payment policies for physical therapy services. Per MLN Matters® Number: MM7050, with an Implementation Date: January 3, 2011, the following policies apply: **"**Many therapy services are time-based codes, i.e., multiple units may be billed for a single procedure. The Centers for Medicare & Medicaid Services (CMS) is applying a MPPR to the practice expense payment when more than one unit or procedure is provided to the same patient on the same day, i.e., the MPPR applies to multiple units as well as multiple procedures. Full payment is made for the unit or procedure with the highest PE payment. For subsequent units and procedures, furnished to the same patient on the same day, full payment is made for work and malpractice and 80 percent payment for the PE for services furnished in office settings and other non-institutional settings and at 75 percent payment for the PE services furnished in institutional settings... The reduction applies to the HCPCS codes contained on the list of 'always therapy' services that are paid under the MPFS, regardless of the type of provider or supplier that furnishes the services... The MPPR applies to the codes on the list of procedures included with CR7050 as Attachment 1. CR7050 is available at **http://www.cms.gov/Regulations-and-Guidance/Guidance/Transmittals/downloads/R826OTN.pdf.**"

   CPT codes 97110-GPis identified on the "always therapy" code list and is therefore subject to the Multiple Procedure Payment Reduction (MPPR). Reimbursement is calculated as follows:

Procedure code 97110, service date August 3, 2015, represents a professional service with reimbursement determined per §134.203(c). The Medicare fee is the sum of the geographically adjusted work, practice expense and malpractice values multiplied by the conversion factor. The MAR is calculated by substituting the Division conversion factor. For this procedure, the relative value (RVU) for work of 0.45 multiplied by the geographic practice cost index (GPCI) for work of 1.019 is 0.45855. The practice expense (PE) RVU of 0.44 multiplied by the PE GPCI of 0.99 is 0.4356. The malpractice RVU of 0.02 multiplied by the malpractice GPCI of 0.955 is 0.0191. The sum of 0.91325 is multiplied by the Division conversion factor of $56.20 for a MAR of $51.32. Per Medicare policy, when more than one unit of designated therapy services is performed on the same day, full payment is made for the first unit of the procedure with the highest practice expense. Payment for each subsequent unit is reduced by 50% of the practice expense. This procedure does not have the highest PE for this date. The PE reduced rate is $39.08 at 4 units is $156.32.

Procedure code 97110, service date August 7, 2015, represents a professional service with reimbursement determined per §134.203(c). The Medicare fee is the sum of the geographically adjusted work, practice expense and malpractice values multiplied by the conversion factor. The MAR is calculated by substituting the Division conversion factor. For this procedure, the relative value (RVU) for work of 0.45 multiplied by the geographic practice cost index (GPCI) for work of 1.019 is 0.45855. The practice expense (PE) RVU of 0.44 multiplied by the PE GPCI of 0.99 is 0.4356. The malpractice RVU of 0.02 multiplied by the malpractice GPCI of 0.955 is 0.0191. The sum of 0.91325 is multiplied by the Division conversion factor of $56.20 for a MAR of $51.32. Per Medicare policy, when more than one unit of designated therapy services is performed on the same day, full payment is made for the first unit of the procedure with the highest practice expense. Payment for each subsequent unit is reduced by 50% of the practice expense. This procedure does not have the highest PE for this date. The PE reduced rate is $39.08 at 3 units is $117.24.

Procedure code 97110, service date August 10, 2015, represents a professional service with reimbursement determined per §134.203(c). The Medicare fee is the sum of the geographically adjusted work, practice expense and malpractice values multiplied by the conversion factor. The MAR is calculated by substituting the Division conversion factor. For this procedure, the relative value (RVU) for work of 0.45 multiplied by the geographic practice cost index (GPCI) for work of 1.019 is 0.45855. The practice expense (PE) RVU of 0.44 multiplied by the PE GPCI of 0.99 is 0.4356. The malpractice RVU of 0.02 multiplied by the malpractice GPCI of 0.955 is 0.0191. The sum of 0.91325 is multiplied by the Division conversion factor of $56.20 for a MAR of $51.32. Per Medicare policy, when more than one unit of designated therapy services is performed on the same day, full payment is made for the first unit of the procedure with the highest practice expense. Payment for each subsequent unit is reduced by 50% of the practice expense. This procedure does not have the highest PE for this date. The PE reduced rate is $39.08 at 4 units is $156.32.

Procedure code 97110, service date August 12, 2015, represents a professional service with reimbursement determined per §134.203(c). The Medicare fee is the sum of the geographically adjusted work, practice expense and malpractice values multiplied by the conversion factor. The MAR is calculated by substituting the Division conversion factor. For this procedure, the relative value (RVU) for work of 0.45 multiplied by the geographic practice cost index (GPCI) for work of 1.019 is 0.45855. The practice expense (PE) RVU of 0.44 multiplied by the PE GPCI of 0.99 is 0.4356. The malpractice RVU of 0.02 multiplied by the malpractice GPCI of 0.955 is 0.0191. The sum of 0.91325 is multiplied by the Division conversion factor of $56.20 for a MAR of $51.32. Per Medicare policy, when more than one unit of designated therapy services is performed on the same day, full payment is made for the first unit of the procedure with the highest practice expense. Payment for each subsequent unit is reduced by 50% of the practice expense. This procedure does not have the highest PE for this date. The PE reduced rate is $39.08 at 4 units is $156.32.

Procedure code 97110, service date August 17, 2015, represents a professional service with reimbursement determined per §134.203(c). The Medicare fee is the sum of the geographically adjusted work, practice expense and malpractice values multiplied by the conversion factor. The MAR is calculated by substituting the Division conversion factor. For this procedure, the relative value (RVU) for work of 0.45 multiplied by the geographic practice cost index (GPCI) for work of 1.019 is 0.45855. The practice expense (PE) RVU of 0.44 multiplied by the PE GPCI of 0.99 is 0.4356. The malpractice RVU of 0.02 multiplied by the malpractice GPCI of 0.955 is 0.0191. The sum of 0.91325 is multiplied by the Division conversion factor of $56.20 for a MAR of $51.32. Per Medicare policy, when more than one unit of designated therapy services is performed on the same day, full payment is made for the first unit of the procedure with the highest practice expense. Payment for each subsequent unit is reduced by 50% of the practice expense. This procedure does not have the highest PE for this date. The PE reduced rate is $39.08 at 2 units is $78.16.

Procedure code 97110, service date August 24, 2015, represents a professional service with reimbursement determined per §134.203(c). The Medicare fee is the sum of the geographically adjusted work, practice expense and malpractice values multiplied by the conversion factor. The MAR is calculated by substituting the Division conversion factor. For this procedure, the relative value (RVU) for work of 0.45 multiplied by the geographic practice cost index (GPCI) for work of 1.019 is 0.45855. The practice expense (PE) RVU of 0.44 multiplied by the PE GPCI of 0.99 is 0.4356. The malpractice RVU of 0.02 multiplied by the malpractice GPCI of 0.955 is 0.0191. The sum of 0.91325 is multiplied by the Division conversion factor of $56.20 for a MAR of $51.32. Per Medicare policy, when more than one unit of designated therapy services is performed on the same day, full payment is made for the first unit of the procedure with the highest practice expense. Payment for each subsequent unit is reduced by 50% of the practice expense. This procedure does not have the highest PE for this date. The PE reduced rate is $39.08 at 3 units is $117.24.

Procedure code 97110, service date September 4, 2015, represents a professional service with reimbursement determined per §134.203(c). The Medicare fee is the sum of the geographically adjusted work, practice expense and malpractice values multiplied by the conversion factor. The MAR is calculated by substituting the Division conversion factor. For this procedure, the relative value (RVU) for work of 0.45 multiplied by the geographic practice cost index (GPCI) for work of 1.019 is 0.45855. The practice expense (PE) RVU of 0.44 multiplied by the PE GPCI of 0.99 is 0.4356. The malpractice RVU of 0.02 multiplied by the malpractice GPCI of 0.955 is 0.0191. The sum of 0.91325 is multiplied by the Division conversion factor of $56.20 for a MAR of $51.32. Per Medicare policy, when more than one unit of designated therapy services is performed on the same day, full payment is made for the first unit of the procedure with the highest practice expense. Payment for each subsequent unit is reduced by 50% of the practice expense. This procedure does not have the highest PE for this date. The PE reduced rate is $39.08 at 3 units is $117.24.

Procedure code 97110, service date September 8, 2015, represents a professional service with reimbursement determined per §134.203(c). The Medicare fee is the sum of the geographically adjusted work, practice expense and malpractice values multiplied by the conversion factor. The MAR is calculated by substituting the Division conversion factor. For this procedure, the relative value (RVU) for work of 0.45 multiplied by the geographic practice cost index (GPCI) for work of 1.019 is 0.45855. The practice expense (PE) RVU of 0.44 multiplied by the PE GPCI of 0.99 is 0.4356. The malpractice RVU of 0.02 multiplied by the malpractice GPCI of 0.955 is 0.0191. The sum of 0.91325 is multiplied by the Division conversion factor of $56.20 for a MAR of $51.32. Per Medicare policy, when more than one unit of designated therapy services is performed on the same day, full payment is made for the first unit of the procedure with the highest practice expense. Payment for each subsequent unit is reduced by 50% of the practice expense. This procedure does not have the highest PE for this date. The PE reduced rate is $39.08 at 4 units is $156.32.

Procedure code 97110, service date September 11, 2015, represents a professional service with reimbursement determined per §134.203(c). The Medicare fee is the sum of the geographically adjusted work, practice expense and malpractice values multiplied by the conversion factor. The MAR is calculated by substituting the Division conversion factor. For this procedure, the relative value (RVU) for work of 0.45 multiplied by the geographic practice cost index (GPCI) for work of 1.019 is 0.45855. The practice expense (PE) RVU of 0.44 multiplied by the PE GPCI of 0.99 is 0.4356. The malpractice RVU of 0.02 multiplied by the malpractice GPCI of 0.955 is 0.0191. The sum of 0.91325 is multiplied by the Division conversion factor of $56.20 for a MAR of $51.32. Per Medicare policy, when more than one unit of designated therapy services is performed on the same day, full payment is made for the first unit of the procedure with the highest practice expense. Payment for each subsequent unit is reduced by 50% of the practice expense. This procedure does not have the highest PE for this date. The PE reduced rate is $39.08 at 3 units is $117.24.

Procedure code 97110, service date September 14, 2015, represents a professional service with reimbursement determined per §134.203(c). The Medicare fee is the sum of the geographically adjusted work, practice expense and malpractice values multiplied by the conversion factor. The MAR is calculated by substituting the Division conversion factor. For this procedure, the relative value (RVU) for work of 0.45 multiplied by the geographic practice cost index (GPCI) for work of 1.019 is 0.45855. The practice expense (PE) RVU of 0.44 multiplied by the PE GPCI of 0.99 is 0.4356. The malpractice RVU of 0.02 multiplied by the malpractice GPCI of 0.955 is 0.0191. The sum of 0.91325 is multiplied by the Division conversion factor of $56.20 for a MAR of $51.32. Per Medicare policy, when more than one unit of designated therapy services is performed on the same day, full payment is made for the first unit of the procedure with the highest practice expense. Payment for each subsequent unit is reduced by 50% of the practice expense. This procedure does not have the highest PE for this date. The PE reduced rate is $39.08 at 3 units is $117.24.

Procedure code 97110, service date September 21, 2015, represents a professional service with reimbursement determined per §134.203(c). The Medicare fee is the sum of the geographically adjusted work, practice expense and malpractice values multiplied by the conversion factor. The MAR is calculated by substituting the Division conversion factor. For this procedure, the relative value (RVU) for work of 0.45 multiplied by the geographic practice cost index

(GPCI) for work of 1.019 is 0.45855. The practice expense (PE) RVU of 0.44 multiplied by the PE GPCI of 0.99 is 0.4356. The malpractice RVU of 0.02 multiplied by the malpractice GPCI of 0.955 is 0.0191. The sum of 0.91325 is multiplied by the Division conversion factor of $56.20 for a MAR of $51.32. Per Medicare policy, when more than one unit of designated therapy services is performed on the same day, full payment is made for the first unit of the procedure with the highest practice expense. Payment for each subsequent unit is reduced by 50% of the practice expense. This procedure does not have the highest PE for this date. The PE reduced rate is $39.08 at 2 units is $78.16.

Procedure code 97110, service date September 23, 2015, represents a professional service with reimbursement determined per §134.203(c). The Medicare fee is the sum of the geographically adjusted work, practice expense and malpractice values multiplied by the conversion factor. The MAR is calculated by substituting the Division conversion factor. For this procedure, the relative value (RVU) for work of 0.45 multiplied by the geographic practice cost index (GPCI) for work of 1.019 is 0.45855. The practice expense (PE) RVU of 0.44 multiplied by the PE GPCI of 0.99 is 0.4356. The malpractice RVU of 0.02 multiplied by the malpractice GPCI of 0.955 is 0.0191. The sum of 0.91325 is multiplied by the Division conversion factor of $56.20 for a MAR of $51.32. Per Medicare policy, when more than one unit of designated therapy services is performed on the same day, full payment is made for the first unit of the procedure with the highest practice expense. Payment for each subsequent unit is reduced by 50% of the practice expense. This procedure does not have the highest PE for this date. The PE reduced rate is $39.08 at 2 units is $78.16.

Procedure code 97110, service date September 25, 2015, represents a professional service with reimbursement determined per §134.203(c). The Medicare fee is the sum of the geographically adjusted work, practice expense and malpractice values multiplied by the conversion factor. The MAR is calculated by substituting the Division conversion factor. For this procedure, the relative value (RVU) for work of 0.45 multiplied by the geographic practice cost index (GPCI) for work of 1.019 is 0.45855. The practice expense (PE) RVU of 0.44 multiplied by the PE GPCI of 0.99 is 0.4356. The malpractice RVU of 0.02 multiplied by the malpractice GPCI of 0.955 is 0.0191. The sum of 0.91325 is multiplied by the Division conversion factor of $56.20 for a MAR of $51.32. Per Medicare policy, when more than one unit of designated therapy services is performed on the same day, full payment is made for the first unit of the procedure with the highest practice expense. Payment for each subsequent unit is reduced by 50% of the practice expense. This procedure does not have the highest PE for this date. The PE reduced rate is $39.08 at 2 units is $78.16.

Procedure code 97110, service date September 28, 2015, represents a professional service with reimbursement determined per §134.203(c). The Medicare fee is the sum of the geographically adjusted work, practice expense and malpractice values multiplied by the conversion factor. The MAR is calculated by substituting the Division conversion factor. For this procedure, the relative value (RVU) for work of 0.45 multiplied by the geographic practice cost index (GPCI) for work of 1.019 is 0.45855. The practice expense (PE) RVU of 0.44 multiplied by the PE GPCI of 0.99 is 0.4356. The malpractice RVU of 0.02 multiplied by the malpractice GPCI of 0.955 is 0.0191. The sum of 0.91325 is multiplied by the Division conversion factor of $56.20 for a MAR of $51.32. Per Medicare policy, when more than one unit of designated therapy services is performed on the same day, full payment is made for the first unit of the procedure with the highest practice expense. Payment for each subsequent unit is reduced by 50% of the practice expense. This procedure does not have the highest PE for this date. The PE reduced rate is $39.08 at 3 units is $117.24.

The Division finds that the requestor is entitled to reimbursement in the amount of $1,641.36. Therefore, this amount is recommended.

Conclusion

For the reasons stated above, the Division finds that the requestor has established that additional reimbursement is due. As a result, the amount ordered is $1,641.36.

ORDER

Based upon the documentation submitted by the parties and in accordance with the provisions of Texas Labor Code Sections 413.031 and 413.019 (if applicable), the Division has determined that the requestor is entitled to additional reimbursement for the services involved in this dispute. The Division hereby ORDERS the respondent to remit to the requestor the amount of $1,641.36 plus applicable accrued interest per 28 Texas Administrative Code §134.130, due within 30 days of receipt of this Order.

Authorized Signature

		June 24, 2016
Signature	Medical Fee Dispute Resolution Officer	Date

YOUR RIGHT TO APPEAL

Either party to this medical fee dispute has a right to seek review of this decision in accordance with 28 Texas Administrative Code §133.307, 37 *Texas Register* 3833, applicable to disputes filed on or after June 1, 2012.

A party seeking review must submit a **Request to Schedule a Benefit Review Conference to Appeal a Medical Fee Dispute Decision** (form **DWC045M**) in accordance with the instructions on the form. The request must be received by the Division within **twenty** days of your receipt of this decision. The request may be faxed, mailed or personally delivered to the Division using the contact information listed on the form or to the field office handling the claim.

The party seeking review of the MFDR decision shall deliver a copy of the request to all other parties involved in the dispute at the same time the request is filed with the Division. **Please include a copy of the *Medical Fee Dispute Resolution Findings and Decision*** together with any other required information specified in 28 Texas Administrative Code §141.1(d).

Si prefiere hablar con una persona en español acerca de ésta correspondencia, favor de llamar a 512-804-4812.